

**DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration (SAMHSA)
Center for Substance Abuse Treatment (CSAT)**

**Minutes of the
45th Meeting of the
CSAT National Advisory Council
February 2-3, 2006**

**1 Choke Cherry
Sugarloaf and Seneca Conference Rooms
Rockville, Maryland 20857**

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**Draft Minutes
45th Meeting of the
CSAT National Advisory Council
Rockville, Maryland
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Thursday, February 3. CSAT Director H. Westley Clark, M.D., J.D., M.P.H., convened the open session on February 2, 2006, at 9:15 a.m. Members present included Anita B. Bertrand, M.S.W.; Kenneth A. DeCerchio, M.S.W.; Melody M. Heaps, M.A.; Valera Jackson, M.S.; Chilo L. Madrid, Ph.D.; Francis A. McCorry, Ph.D.; Gregory Skipper, M.D.; Judge Eugene White-fish; and Richard T. Suchinsky, M.D. (ex officio). Also present were George Gilbert, J.D., Acting Deputy Director, CSAT, and Cynthia A. Graham, M.S., Executive Secretary, CSAT National Advisory Council.

Welcome. Dr. Clark welcomed participants to the meeting and observed a moment of silence in memory of Dr. Sheila Harmison, former special assistant to Dr. Clark, and Christine Peterson Braverton, daughter of Council member David Peterson.

Minutes, May 14-15, 2005. Council members voted unanimously to accept the minutes of the May 14-15, 2005, CSAT Council meeting as presented.

Council Introductions. Council members introduced themselves and highlighted recent activities. Dr. Heaps reported that Illinois is considering an alcopops tax. Her organization, TACS, has earned press coverage for its work in the state's largest corrections treatment center. Dr. Madrid is working to develop his state association's legislative agenda for 2006 and reported that the Association of Substance Abuse Service Providers sponsored a faith-based conference for 300 teenagers and 100 parents that offered counseling and interventions. Dr. McCorry stated that New York State is promoting adoption of a mental health screen in its substance abuse programs in an effort to adopt a no-wrong-door policy for co-occurring disorders and to support adoption of evidence-based practices. Dr. Clark noted that New York has increased its substance abuse budget by 11 percent. Ms. Jackson noted that she serves as chair of the South Florida Provider Association. Florida now allows managing entities increased autonomy in funding local service providers, including combining substance abuse and mental health dollars. Dr. Suchinsky reported that the Department of Veterans Affairs has implemented its Mental Health Strategic Plan, which increases funding for substance abuse treatment and targets expansion of buprenorphine availability. The VA will hold regional training programs for its physicians for buprenorphine certification. Judge White-fish stated that the National American Indian Court Judges Association and the National Congress of American Indians are addressing the methamphetamine problem. Their work focuses on how to surmount jurisdictional difficulties related to the sovereignty of Indian nations. State and courts are working with Indian courts to address communities' substance abuse problems, particularly by drug courts. Dr. Skipper serves as co-principal investigator on a national study of physician health programs, which enjoy

success in substance dependence treatment. He noted that ethyl glucuronide (EtG), a marker to determine abstinence, has come onto the market, but false positives warrant further study. Ms. Bertrand stated that her work with minority adolescents has expanded to a variety of projects, including peer recovery support and making a documentary film. Mr. DeCerchio reported that Florida is implementing Access to Recovery (ATR), CSAT's Strategic Prevention Framework, and mental health transformation. A workgroup of state agency heads focuses on reducing underage drinking; communities are developing local action plans to integrate substance abuse and mental health services to families in the child welfare system; Brief Referral Intervention Treatment to Elders (BRITE) is generating reductions in use among older adults; and disaster recovery programs continue to provide substance abuse and mental health services.

Director's Report. Dr. Clark enumerated staff changes at CSAT. Richard Kopanda serves temporarily as CSAP acting director, and George Gilbert serves as CSAT's acting deputy director. Karl White is representing SAMHSA in Vietnam, working with the Office of Global Health on HIV and substance abuse. Dr. Clark pointed out that retirement of CSAT staff members offers opportunities for younger staff to advance. New employees include Jorielle Brown, Sherrye Fowler, Christina Lynn, Lisa Creatura, and Linda Kaplan. Anne Herron serves as acting director, Division of Service Improvement, and John Campbell serves as acting director, Division of State and Community Assistance.

Dr. Clark reported that Congress passed the FY 2006 budget, which appropriates \$398.9 million for CSAT, a reduction of \$48.2 million from the president's request and a \$23.5 million reduction from FY 2005. Congress continued ATR funding at current levels, decreased funding for SAPT block grants by \$17 million (at \$1,758.6 million) from FY 2005, imposed a 1 percent across-the-board reduction in funding, and omitted substantial Congressional earmarks. Work on the FY 2007 budget continues.

Dr. Clark stated that Congress has removed a ban on the 30-patient limit for group practices to administer buprenorphine, and CSAT expects to issue a Notice of Proposed Rulemaking that addresses removing the 30-patient limit on individual practitioners. Several jurisdictions are moving toward electronic prescription monitoring, an activity under discussion at SAMHSA.

CSAT convened a meeting of community and faith-based organizations to increase ATR's focus on recovery support services. CSAT's Community and Faith-Based Technical Assistance Initiative helps community and faith-based organizations build capacity to provide effective services and successfully apply for and receive federal grants. CSAT is pursuing ATR education forums, HIV/AIDS expert panels, and capacity building in communities on HIV/AIDS.

Recovery Month in September 2005 began with a major prevention effort, and planning has begun for 2006. Dr. Clark emphasized the need for communities to view recovery as beneficial to the entire community. One event was the release of the 2004 National Survey on Drug Use and Health, which found that youth ages 12-17 have decreased their drug and alcohol use, but young adults ages 18-25 have not. Recovery Month encompassed 41 community events that reached approximately 35,000 and generated a collective media circulation of 3 million. The "Treat Me" 2005 PSA received two silver Omni Awards and a gold Mercury award.

CSAT is working with the governments of Mexico and Vietnam. Dr. Clark reported that although the number of home labs that produce methamphetamine has declined, use of the drug has not. Purity, cost, and related crime are also increasing. Mexico exports methamphetamine to the U.S., making a positive relationship with Mexico important to address the issue.

Dr. Clark enumerated several additional CSAT activities. CSAT and the National Association of Children of Alcoholics launched a pilot nondenominational recovery training program for clergy leaders and congregants. Several new consumer publications are available. CSAT is working with NIH to obtain the most recent information possible to share with communities. CSAT's helpline usage continues to grow. CSAT will host community education forums on medication assisted therapies. Tracking of buprenorphine reveals some diversion among people who cannot afford the medication, but drug companies have created a compassionate program to which people without resources can apply. Two publications on methadone are under development.

Discussion. Ms. Heaps suggested adding presentations on SBIRT and ATR to an upcoming Council agenda. Ms. Jackson suggested renewed focus on e-therapy.

SAMHSA Update. Mr. Charles G. Curie, M.A., A.C.S.W., Administrator, SAMHSA, noted the evolution of recovery from a personal process to ATR, a presidential initiative that embraces public policy and public finance. Initial ATR data from states indicate areas of success and areas for additional attention. Mr. Curie asserted that ATR reflects many pathways to recovery. He noted the need for accountability based on outcomes, a focus on public safety, and ensuring that providers are eligible and transparent. He discussed the political issue related to faith-based providers, asserting that ATR is based on choice and noting the importance of acknowledging persons' experiences with faith in their recovery. Although Mr. Curie stated that he considers CSAT's reduced budget to be a lost opportunity to expand treatment capacity, ATR has met its first-year goal of serving 25,000 clients, and participation of recovery support services providers, including faith-based providers, is increasing. Mr. Curie noted that many success stories are emerging. The ATR program is the first major initiative to implement the National Outcome Measures System (NOMS) to measure recovery and the impact of services. Mr. Curie views NOMS as a way to measure the effectiveness of all SAMHSA's discretionary and block grant initiatives with states. He noted states' concerns about how outside groups may rank state data. Profiles of ATR states are presented on the SAMHSA website (www.samhsa.gov).

Mr. Curie announced updates to the SAMHSA Matrix. Disaster response and readiness, formerly a priority program, has become a cross-cutting principle; suicide prevention has been added as a priority; and workforce development has been moved from a cross-cutting principle to a priority. Mr. Curie assured Council members that the proposed FY 2007 lean budget nevertheless will reveal opportunities for innovation and further operationalization of recovery.

Discussion. Dr. McCorry suggested framing ATR as a way to provide continuing care in the community for treatment for substance abuse, much as primary medical care is followed up in one's home. Faith-based providers of recovery support services offer important ongoing relationships. Mr. Curie concurred, noting, however, that controversy arises over situations in which persons choose to access faith-based recovery support services without prior contact with

medical care. Nevertheless, many people in recovery claim that each experience helps incrementally, a claim supported by the research. Ms. Heaps stated that ATR represents a systems change and asserted the need to help smaller community- and faith-based organizations develop capacity and to communicate that it will take time to enhance the infrastructure. She noted that federal demonstration programs traditionally have at least three years to develop their projects. Mr. Curie concurred, responding that it is necessary to refer to the expectations cited in the RFA, especially when looking at the early data. He noted that states varied in their use of vouchers for ATR's first year, but he congratulated them for their accomplishments. Dr. Madrid stated that, as a provider, he is becoming more comfortable with ATR. Drug court activity is rising, a positive development. He encouraged training groups of faith-based providers.

Mr. DeCerchio cited concerns about federal oversight agencies' rating of the block grant as ineffective in its ability to demonstrate its effectiveness. Mr. Curie responded that as NOMS generate data on how states spend their block grant funds, positive outcomes data will demonstrate accountability to federal oversight agencies. He noted that SAMHSA might encourage and work with states to spend block grant dollars in ways that can demonstrate outcomes more quickly. He asserted that pressure from oversight agencies to produce positive outcome data does not imply an automatic cut to block grant funding; however, low scoring programs may be subject to cuts. Ms. Jackson urged retaining discretionary funds as part of the block grant and developing a system for using skilled, but unlicensed, volunteers in disaster response. Mr. Curie concurred with the need to discuss unintentional barriers with states. Ms. Bertrand reported that she participated in the National Recovery Summit, lauded the administration's efforts to focus on services at the community level, and stated that outcomes can be improved by enlisting volunteers.

Recovery Summit Update. Cathy Nugent, M.S., LGPC, CP, Project Officer, Addiction Technology Transfer (ATTC) Program, CSAT, reported on the September 2005 CSAT sponsored summit, at which diverse stakeholders shaped a vision of a recovery oriented system of care. Approximately 100 representatives of the treatment and recovery field developed new ideas to help move toward a recovery oriented paradigm; articulated principles and measures of recovery; and generated ideas for advancing a recovery-oriented system of care in a variety of settings and systems. The summit followed a planning group meeting whose participants, representing diverse stakeholder groups, discussed key issues and informed the agenda. This group met again to synthesize and validate the summit's findings and to develop next steps.

The summit developed 13 overarching principles of recovery at the individual level and 17 elements at the systems level of a recovery oriented system of care. The summit also developed recommendations for CSAT and for systems professionals, researchers, treatment providers, recovery service providers, advocates, and mutual aid groups. The summit recommended that CSAT conduct an inventory of recovery oriented products, programs, activities, and services; convene a research summit; conduct outreach; convene regional meetings; provide education and technical assistance on recovery oriented approaches; facilitate a discussion of the ethical framework for peer recovery support services; promote and encourage development of financing models; and continue to ensure that CSAT initiatives reflect a full range of voices of recovery.

The summit's deliberations are informing a CSAT action plan to infuse recovery principles and measures into policies, programs, and services. CSAT plans to host a series of regional meetings to vet and refine the principles and elements of recovery, and to develop strategies to implement the recommendations at the community and state levels. The synthesis group developed a working definition of recovery from alcohol and drug problems, "a process of change through which an individual achieves abstinence and improved health, wellness, and quality of life," that will be vetted with the field. CSAT staff are developing a report of the summit.

Discussion. Ms. Bertrand stated that the summit participants anticipated ongoing dialogue. Dr. Madrid noted that participants concurred in the multiple pathways to recovery approach.

Partners for Recovery Update. Donna Cotter, M.B.A., Coordinator, Partners for Recovery, CSAT, stated that Partners for Recovery (PFR) (and its predecessors) has operated for an unprecedented nine years within CSAT/SAMHSA. Ms. Cotter presented an overview of its new website (www.pfr.samhsa.gov), which highlights mental health and prevention as well as substance abuse disorders, and provides information and resources related to specific focus areas, and latest news. She asked Council members to provide state-level input to populate the website and also links to their websites.

PFR plans to conduct approximately 22 events nationwide, some in conjunction with partner organizations. One effort will educate state legislators on performance measures in addiction treatment and on the phenomenon of relapse. Publications include "Know Your Rights," to be used in regional training programs. Ms. Cotter asked Council for recommendations for attorneys to be targeted for attendance. She noted that people in recovery, provider organizations, and state representatives are encouraged to attend, and that the Legal Action Center will offer technical assistance to states that have not experienced direct training.

Public Comment. There were no comments from the public during the Public Comment period.

Council Discussion. Dr. Clark announced SAMHSA's National Conference on Returning Veterans, scheduled for March 2006, in partnership with the Therapeutics Communities of America, with a focus on roles that community-based organizations, states, and others can play. Ms. Jackson highlighted the importance of SAMHSA's workforce issues priority. Dr. Clark stated that workforce development encompasses the needs of state officials and their policies for certification, licensing, reimbursement, and related issues; providers' needs; and services to use. The Annapolis Coalition continues to work on the issue, and CSAT is preparing a response to Congress. Dr. McCorry urged increased attention to the NIDA Oval treatment model, which addresses the complexities of treatment and includes wraparound, case management, clinical supervision, and medication management services.

National Health Information Infrastructure. John Carnevale, Ph.D., President, Carnevale Associates, LLC, and Chair, Behavioral Health Treatment Standards Workgroup, described the National Health Information Infrastructure (NHII), whose origins in concerns about a health care crisis in the 1990s and a 1990 Institute of Medicine (IOM) report on the issue, led to the impetus for a modern electronic health information support system to improve effectiveness of the

delivery of health care services. Dr. Carnevale cited a series of events that led to the public-private partnership to build NHII, including a 2004 Executive Order that established the Office of the National Coordinator for Health Information Technology (ONCHIT) and set a goal for broad adoption by 2014 of interoperable electronic health records (EHR). The National Health Information Network refers to a comprehensive, interoperable knowledge base under construction, but not central or national in scope.

ONCHIT's American Health Information Community, a committee of representatives from hospitals, insurance companies, information technology (IT) experts, and federal and state agencies that advises the HHS Secretary, focuses on EHR, a system that includes longitudinal data for and about people, enables electronic access to people- and population-level information by authorized users, provides knowledge and decision-support systems, and promotes efficiency in the industry. The EHR is maintained by providers; a patient health record (PHR) is a subset of that information that incorporates a person's history.

Dr. Carnevale identified as challenges the management of information to improve patient care and safety, while also protecting patients' rights and privacy, and integration of substance abuse and mental health treatment into national efforts to modernize and become more mainstream. Research has found that IT in these systems is used primarily for administrative reporting purposes, and that the necessary capacity is lacking to improve clinical decision making or program planning.

The Behavioral Health Treatment Standards Workgroup works toward increasing knowledge, understanding, and use of behavioral health standards in substance abuse and mental health. It identifies opportunities to influence standards and setting activities by organizations that coordinate information exchange standards. Volunteer membership in this policy group includes almost three dozen entities representing national, state, and local substance abuse and mental health organizations, software vendors, and consumer groups. The workgroup's long-term priorities include developing standards regarding the EHR, e-prescription drug monitoring programs, and performance measurement and management. The workgroup's current activities include raising awareness about the issues, participating in standard setting, and expanding its membership.

Discussion. Dr. McCorry observed the importance of proactive involvement in setting standards. Dr. Carnevale stated that much work must be done with limited resources. He noted that CMHS and CSAP have joined CSAT in the process. Dr. Carnevale explained that standard setting will be completed soon, and that consumers factor into the equation in that the standards focus on patient safety, care, and health.

Campus Screening and Brief Intervention. Tom Stegbauer, M.B.A., Acting Branch Chief, Organization and Financing Branch, CSAT, presented an update of the SBIRT (Screening Brief Intervention and Referral to Treatment) college program, which targets low-risk drinkers for education and at-risk drinkers for an intervention. In addition, the program helps people who are dependent to access appropriate care. In FY 2003 SAMHSA awarded SBIRT grants to six states and one tribal organization, and an effort is underway to address college and university drinking

patterns.

Research shows that 43 percent of students consume alcohol at at-risk levels; college students are more likely to binge drink than other groups; and more people aged 18-22 enrolled in colleges drink excessively than other cohorts of the same age. In addition, a third of students use illicit drugs or prescription drugs in an inappropriate way. Research also reveals evidence of the epidemic consequences of college drinking in terms of deaths, assaults, and injuries.

CSAT has made awards to 11 universities and one junior college, each of which integrates screening and brief intervention (SBI) uniquely into its campus health programs, to screen 70,000 students annually. One institution is private and the rest public; some use computer based technologies; some accept judicial referrals; and many work with their athletic programs. Mr. Stegbauer highlighted various features of the programs, many of which refer their treatments outside the university and several of which are just beginning to operate.

Although no data was available for the college program, GPRA performance data reported by SBIRT grantees show that six months after an intervention, 50 percent of participants have abstinence from alcohol of more than 30 days. In addition, the use rate for illicit drugs has declined by 42 percent. Of 320,000 patients, more than 15 percent receive either an intervention or treatment, and more than 5 percent receive either brief or long-term treatment.

In describing future activities, Dr. Stegbauer stated that FY 2006 funds are expected to be available for another round of RFAs at the state level, and a study is underway to help groups and states overturn laws that deny insurance coverage for medical treatment for alcohol or illicit drug use. CSAT is conducting a cross-site evaluation to understand variability between sites. A Sustainability Workgroup is looking at issues to carry forward the work.

Discussion. Dr. McCorry observed that large numbers of screened college students bypassed the brief intervention and entered treatment. To Dr. Madrid's question on numbers of students sent through the ATR system, Mr. Stegbauer responded that information has not been collected on that dimension and the concept behind the SBIRT grant did not incorporate ATR.

Institute of Medicine Report. Constance Weisner, Dr.P.H., M.S.W., Professor, Department of Psychiatry, University of California–San Francisco, Investigator, Division of Research, Kaiser Permanente Medical Care Program, discussed the new IOM report “Improving the Quality of Health Care for Mental Health and Substance-Use Conditions, Quality Chasm Series” (<http://darwin.nap.edu/books/0309100445/html>), a sequel to the IOM's “Crossing the Quality Chasm” (www.nap.edu/books/0309072808/html). Dr. Weisner noted that the earlier report omitted a focus on mental health and substance use (MH/SU) treatment.

In its new report the IOM explores implications of “Quality Chasm” for the field of mental health and addictive disorders; identifies barriers and facilitators to achieving significant improvements along its six dimensions (safety, effectiveness, patient centricity, timeliness, efficiency, and equitability); examines environmental factors and health care organization and delivery issues; and presents an agenda for change. A committee of representatives from the

MH/SU fields concluded that improving care delivery and outcomes for any problems of mental health, substance use, or general health depends upon improving care outcomes for the other two areas; the committee acknowledged the issue of comorbidity versus primary disorders. Their overarching recommendation is that health care for general, mental, and substance use problems and illnesses must be delivered with an understanding of the inherent interactions between the mind/brain and the rest of the body.

The committee identified issues that warranted compilation of an additional report, including increased stigma, discrimination, and coercion in MH/SU compared to health; patient decision-making ability less anticipated and supported by the system; more subjective diagnoses; less-developed quality measurement and improvement infrastructure; more separate care delivery arrangements; less involvement in NHII and use of IT; more diverse workforce and more solo practice; and a differently structured marketplace. Dr. Weisner summarized the IOM report's discussion of problems in the quality of health care and MH/SU and proposed solutions:

1. Change the culture at care delivery sites to combat stigma and consumer support decision making; involve consumers more in the design, administration, and delivery of care; provide decision making support to consumers, including peer support and advance directives; support recovery programs and practices; make transparent policies for determining decision making capacity and dangerousness; and preserve patient decision making in instances of coercion.
2. Weak measurement and improvement infrastructure. The MH/SU fields have not produced an evidence base efficiently. Strategies include filling gaps in the evidence by studying existing programs that are doing well; standardizing and coding interventions, outcome measurements, and coordination of initiatives to analyze the evidence; building infrastructure for measuring and reporting quality; and supporting Quality Improvement practices.
3. Poor linkages across separations in care. Accountability for coordination is unclear. Mechanisms should be put in place for coordinating care and sharing patient information between providers, with patient knowledge and consent; targeted screening for health, mental health, and substance use in each system of care; better evidence based coordination and linking mechanisms, and high-level policy coordination mechanisms that achieve and model collaboration at the federal and state levels are needed.
4. Lack of involvement in the NHII in the design of EHRs, data standards, and a platform for exchanging information across clinical settings. Actions needed involve DHHS and the VA to charge ONCHIT and SAMHSA jointly to develop and implement a plan to ensure that the NHII addresses MH/SU health care as fully as general health care.
5. Insufficient workforce capacity. Issues include an aging workforce; greater variation in the MH/SU workforce and its education and training than in other health care. Remedies include sustained national attention and creation of a federally funded public private Council on the Mental and Substance Use Health Care Workforce, which would collaborate with SAMHSA and institutions of higher learning to develop standards for training and licensure.
6. Differently structured marketplace. The MH/SU marketplace is dominated by government purchasers, a carve-out system for most services, more limited coverage compared to other health conditions, and substance use not as well covered as mental health, including Medicaid. Recommended strategies include tools for reducing adverse selection by insurers,

enactment of insurance coverage parity, re-orientation of state procurement entities to quality rather than only cost savings, and using quality measures in making funding decisions.

Dr. Weisner highlighted selected IOM report recommendations:

- Individual clinicians should focus on patient centered decision making, screening for co-occurring conditions, routinely assessing outcomes, finding ways to share information clinically with other providers, and provide coordination.
- Organizations providing care should develop policies to enable and support all clinicians' actions; involve patients and families in the design, administration, and delivery of services; link with other systems; and become involved in the NHII.
- Health plans/purchasers should pay for recovery-oriented services, peer support, and illness self-management; provide patients with comparative information on quality of services and providers; remove payment and service exclusions; support development of quality measurement and improvement; work on sharing patient information appropriately among primary care, mental health, and substance use; provide incentives for IT; use tools to reduce adverse risk selection; and use measures of quality and coordination.
- State policy officials should make coercion policies transparent, revise laws that make communication between providers difficult, create high level mechanisms to improve collaboration and coordination across agencies, work on parity, and reorient state procurement processes toward quality.
- Federal policy officials. DHHS should coordinate identification of evidence-based practices, develop procedure codes for administrative data sets, use evidence-based approaches to disseminate and promote uptake of evidence-based practices, assure use of general health care opinion leaders in dissemination, fulfill essential quality measurement and reporting functions, provide leadership in quality improvement, and provide a continuum among federal agencies. The federal government also should revise laws, rules, and other policies that obstruct sharing of information across providers, taking confidentiality into consideration; continue to fund demonstrations to transition to evidence-based care; make sure that the NHII addresses information infrastructure and MH/SU care; authorize and fund a council on the workforce; support faculty leaders in health profession schools; and provide leadership development support, and funding for research and development on QI in care.
- Accrediting bodies should adopt standards to measure patient centered decision making throughout care; involve consumers in the design, administration, and delivery of services; require formal linkages with community resources; and use evidence-based approaches to coordinating care.
- Funders of research should support development and refinement of tools easy to use in screening and in assessing response to treatment, creation of a set of MH/SU "vital signs," and take advantage of what is known on the ground.

Dr. Weisner stated that the recommendations on improving health care in "Quality Chasm" should be applied throughout MH/SU health care, tailored to reflect the its unique characteristics.

Institute of Medicine Report: CSAT's Activities. Sarah Wattenberg, LCSW-C, SAMHSA HIPAA Coordinator, CSAT, noted that three substance abuse representatives served on the committee of two dozen persons. Ms. Wattenberg stated that CSAT co-sponsored a meeting with the Robert Wood Johnson Foundation (RWJ) attended by substance abuse treatment leaders to elicit the field's priorities. Although they observed that a context for providing substance abuse treatment was omitted, they asserted that sufficient information and recommendations enabled them to endorse the report.

Because CSAT has been taking a number of recommended actions, it appears that the Center is on track. CSAT will use the report to identify new initiatives and support those in the pipeline. The first recommendation is to create a crosswalk between IOM recommendations and CSAT's activities to identify gaps and to set priorities for resources. In this effort, it is hoped that IOM will make a second presentation to CSAT on the report.

Discussion. Dr. McCorry expressed concern that substance abuse in the criminal justice system was not addressed in the report and noted the limited press coverage of the report's release. Ms. Wattenberg responded that the final report may be relaunched, but that the field has begun to respond. Dr. Clark noted that the report also omitted reference to the Health Resources and Services Administration (HRSA). Dr. Weisner stated that the HRSA model program must be discussed broadly. She noted that another topic omitted from the report, because a separate IOM study focuses on it, is health care in minorities and culture. IOM focuses on health reports, but the report alluded to school problems and addressed such issues as criminal justice in mention of linkages outside the health care field. Ms. Wattenberg responded that funding and process issues may impede IOM from producing supplementary materials, but that a journal might devote an issue to the substance abuse field's response to the report. Dr. Weisner responded to a question from Mr. DeCerchio that the issue of carve-out versus integration is a heated issue on the IOM committee, reflecting lack of consensus in the field on action steps. Ms. Heaps urged CSAT to find a mechanism to translate the IOM report and set standards for treatment in the criminal justice system. Dr. Clark observed the need to examine the IOM report's framework and address its specifics in order to advise the administrator on areas of concern specific to substance abuse treatment and prevention. He noted that mention of the child welfare system and the issue of impaired health and other professionals were omitted in the report. He also suggested that the report be viewed in the context of the needs of community and faith-based organizations as providers of recovery oriented services within the continuum of care. Dr. Clark noted that CSAT is contributing subject matter expertise to the NHII process.

SAMHSA Hepatitis A and B Vaccine Initiative. Kenneth Hoffman, M.D., M.P.H., Medical Officer, Division of Pharmacologic Therapies, CSAT, described the SAMHSA Hepatitis A and B Vaccine Initiative, which aims to establish cooperative agreements with substance abuse treatment settings in order to enhance vaccination against hepatitis A and B infections for patients at risk for HIV and/or hepatitis C, and also to evaluate the vaccine's distribution and outcomes. Although the main focus ultimately is on hepatitis C, inoculating high-risk individuals for A and B can help to improve quality of life, survival, and capability to function while focusing on the individual as a whole, rather than on the specific disease of substance abuse. The initiative is unique in SAMHSA.

Approximately two dozen organizations that assess and manage HIV and HCV have accepted CSAT's invitation to participate, including opioid and buprenorphine treatment settings and CSAP and CSAT Minority AIDS Initiative grantees. Contractors distribute the vaccine and conduct the descriptive evaluation.

Analysis to date estimates a potential of 50-2,000 patients per program, up to a total of 15,000 patients. The initiative has achieved its target with response from larger programs, and Dr. Hoffman explained that it may be possible to make some vaccine available to smaller programs. The analysis reveals the percentage in each group completing one, two, or three shots, as well as safety and adverse events as reflected in VAERS. Dr. Hoffman explained that the initiative aims to identify missed opportunities and to describe connectivity between immunization and substance abuse treatment programs in order to identify best practices.

Discussion. Dr. McCorry commented on the gap between county health departments and substance abuse treatment programs, and noted that the initiative may serve as a catalyst to bring them together. New York State has initiated a pilot program in which two county health departments vaccinate everyone in substance abuse treatment. Dr. McCorry suggested the need also for pneumonia vaccinations. Dr. Hoffman added tuberculosis to the list. Dr. Madrid pointed out that insufficient resources remain impediments to vaccination. Dr. Clark stated that SAMHSA anticipated this issue, and HHS has allocated funds to address it. He pointed out that SAMHSA is working with the National Institute on Drug Abuse (NIDA) and the Centers for Disease Control and Prevention (CDC), and that this initiative represents a concrete effort to integrate CSAT's work with primary care.

Council Roundtable. Ms. Heaps requested a briefing on the workforce development project and asked to see the report on the issue. Dr. Clark responded that once the report to Congress is complete, it will be shared with Council members. He highlighted the importance of adequately trained staff and an appropriate financing structure to address co-occurring depression, anxiety disorders, and psychosis with substance abuse. Dr. Madrid suggested inviting the Annapolis Coalition to make a presentation to the Council.

Adjournment. The meeting adjourned at 4:27 p.m.

Friday, February 3

The open session of the Council meeting resumed at 9:10 a.m. with a welcome from Dr. Clark.

Methamphetamine Update

Cheryl Gallagher, M.A., Public Health Advisor, Systems Improvement Branch, CSAT, discussed CSAT's response to the methamphetamine problem, which began in 1998 with a diverse seven-site Methamphetamine Treatment Project (MTP). A website was established, and two journals published articles about the successful project. MTP found that the Matrix model and sites' treatments-as-usual provided clients with recovery at the same rate as recovery from other drug dependence, with best results from the drug-court site. CSAT also published TIP #33 and companion products on treatment for stimulant use disorders, participated in an Interagency Task Force on Methamphetamine (www.ojp.usdoj.gov/nij/publications/methintf/index.html), collaborated with the State Department to provide technical assistance to Thailand on the Matrix model, and conducted a comprehensive community treatment program on behavioral therapies for gay male stimulant users and alcohol users.

Ms. Gallagher explained that CSAT sponsored a series of conferences and awarded Targeted Capacity Expansion grants to address the problem. CSAT Drug Court grantees are encouraged to establish partnerships with local Drug Endangered Children programs. This program and the MTP program, which offer incentives to enter and stay in treatment, have produced the best results. In ATR Tennessee and Wyoming have identified methamphetamine as their specific target area. CSAT and the Drug Enforcement Agency (DEA) fund governors' summits to develop strategies to address the problem in communities. One Sky, the American Indian/Alaska Native National Resource Center, held a 2005 summit to develop a strategy for tribal lands. ATTCs are expanding training activities, including digital training modules and a presentation on best practices (www.psattc.org). The substance abuse prevention and treatment block grant offers technical assistance to states and is planning regional meetings on effective approaches to treatment. CSAT's methamphetamine workgroup is collaborating with the Indian Health Service to plan meetings; SAMHSA's Workgroup on Synthetic Drugs addresses methamphetamine use; SAMHSA intends to work with ONDCP; and CSAT is working with CDC and CSAP on methamphetamine and infectious diseases.

Discussion. In response to questions from Council members, Ms. Gallagher offered to provide information on state responses to methamphetamine, a drug that is distributed across the country and appears to be on the increase, especially toward the east. Across CSAT's discretionary portfolio, only 5 percent of the population uses methamphetamine. Dr. Clark stated that while the Household Survey does not show an increase in prevalence, it shows increased numbers of people dependent. Also, the number of labs is growing. Ms. Gallagher explained that the drug court site showed better outcomes because of longer treatment periods and positive incentives. Dr. Clark stated that the Household Survey shows Native Americans to be second to whites in the prevalence rate, followed by Hispanics, Asians, and African Americans. Ms. Gallagher noted that treatment capacity in rural areas is a problem. Dr. Clark stated that the Household Survey shows prescription methamphetamine users to be a minority. He noted that Tennessee has highlighted the need to address the methamphetamine problem in every jurisdiction.

CSAT's Strengthening Treatment Access and Retention Program/Network for the Improvement of Addiction Treatment

David Gustafson, Ph.D., Director, Network for the Improvement of Addiction Treatment (NIATx), described NIATx, a partnership that merged CSAT's STAR program and RWJ's Paths to Recovery. Dr. Gustafson asserted that treatment access and retention must improve the overwhelming proportion of people who need care receive no care, and some people leave care prematurely; process improvement works; and state governments are essential to diffusing process improvement.

Dr. Gustafson described his simulated first hand experience in trying to gain access to inpatient or residential care for substance addiction. He identified barriers to care and the dedication of people who work in the field, and found gaps among a range of business processes that impede access. Using process improvement techniques, NIATx aims to reduce waiting times and no-shows, and to increase admissions and continuation rates. Research shows the importance of understanding the customer, targeting only key problems, selecting powerful change leaders, identifying ideas outside the agency, and doing rapid-cycle testing of changes.

Results to date show that 37 change projects in 24 treatment agencies reduced waiting times by 51 percent by instituting walk in appointments; 28 projects in 21 agencies reduced no-shows by 41 percent by identifying and removing barriers, encouraging attendance, and reminding about appointments; 23 projects in 16 agencies increased admissions by 56 percent (one agency by 247 percent) by fostering the transition from detox to outpatient care; and 29 projects in 23 agencies increased their continuation rate by 39 percent by identifying and instituting simple, targeted, rapid-cycle changes. Sustainability of these results is to be determined down the road.

Dr. Gustafson described NIATx's pilot projects for states, which revealed great opportunity for states to improve their own processes. States selected particular aims, partnered with several health care addiction treatment providers, selected process targets, and tested those processes. Iowa reduced waiting times by 38 percent, North Carolina changed eligibility requirements to enable detox patients to move to the next level of care, and Oklahoma eliminated eligibility determination for high performers, reduced waiting time for treatment to three days, reduced duplicative paperwork, and reduced the time necessary for admissions. A follow-up CSAT activity is STAR-SI. Dr. Gustafson explained that NIATx offers all member learning sessions, all-member telephone calls, interest circle calls, coaching, and a website (www.niatx.net).

Discussion. In response to questions from Council members, Dr. Gustafson stated that CSAT and RWJ plan to convene managed care providers to explore merging funders' disparate eligibility requirements. He noted that NIATx focuses on change rather than documenting problem areas. Ms. Fran Cotter stated that no current STAR-SI projects target adolescents specifically, although efforts to do so are underway. Dr. Gustafson explained that paperwork reductions have been addressed successfully in dialogue between providers and some states. Similarities with fields beyond addiction treatment provide opportunities for learning. Mr. DeCerchio observed that the approach links what states try to measure with performance. Ms. Cotter stated that NIATx has compiled empirical data on five promising practices for each of its aims. Dr. Skipper noted that some organizations establish barriers purposely to improve their

outcomes. Dr. Gustafson noted the need to look at the business case behind improvements and to provide incentives for organizations to improve their efficiency and effectiveness.

SAMHSA's Response to Hurricanes Katrina and Rita

Anne Herron, M.S., CRC, CASAC, NCACII, Director, Division of State and Community Assistance, CSAT, presented a slide show illustrating Mississippi's experience. Daniel Dodgen, Ph.D., Emergency Management Coordinator, SAMHSA, noted the late Dr. Harmison's contribution to integrating substance abuse into SAMHSA's disaster preparedness readiness response. Dr. Dodgen then described the National Response Plan, which governs the federal response to any disaster event. An intergovernmental management group of (typically) one senior representative from all federal departments is established; following the 2005 hurricanes, HHS requested a second person from SAMHSA to address substance abuse and mental health issues. The plan also codifies an incident command structure to establish lines of command and federal entities' roles and responsibilities. SAMHSA is involved in several emergency support functions (ESF): ESF6 (maintaining services for people with substance abuse and mental health concerns in shelters), ESF8 (ensuring that public health and medical incorporates substance abuse and mental health issues), ESF14 (long-term community recovery and mitigation), and ESF15 (external affairs—communication with the public, taking into consideration psychological, mental health, and substance abuse issues).

SAMHSA works with the Federal Emergency Management Administration (FEMA) to fulfill states' requests for assistance. Dr. Dodgen asserted that HHS, FEMA, and others are beginning to understand the importance of SAMHSA's contributions to disaster response, including the Crisis Counseling Program (CCP). SAMHSA participates in ESF8 calls to address emerging problems and participates in other key stakeholder groups. Its role is to provide assistance to states in areas where extra help is needed; coordinate resources, assets, and activities; provide subject matter experts; and provide grants for planning, coordination, and response.

Ms. Herron and Brenda Bruun, Special Assistant to the Director, Division of Prevention, Traumatic Stress and Special Programs, CMHS, described how the disaster response structure translated into action when Hurricanes Katrina and Rita hit. Ms. Herron introduced the SAMHSA Emergency Response Center (SERC), which coordinated SAMHSA's activities. Ms. Bruun explained that the SERC coordinated information between the HHS Secretary's operations center and SAMHSA. Its incident command structure, activated for the first time, managed the SERC's personnel, logistics, planning, finance, and public information functions. Ms. Herron stated that SAMHSA has deployed 257 staff to the field and the SERC, half the agency, including 55 of CSAT's 103 staff. Some staff provided direct clinical services, direct administrative assistance to state employees and providers, and managed and monitored volunteers deployed to disaster areas from across the country. Other staff supported SERC operations, including working to replace rapid HIV tests lost in the storm, continuing methadone treatment, disposing of contaminated methadone, and developing data to support substance abuse-specific mission assignments. Staff members who remained at SAMHSA headquarters carried on the business of the agency, a daunting enterprise.

Ms. Bruun stated that as SAMHSA responded, it also trained staff on new responsibilities. SAMHSA provided Emergency Response Grants to Texas, Louisiana, Mississippi, and Alabama to address immediate needs. Staff reviewed initial applications for CCP from 34 states in about a week, and were reviewing 24 complicated applications for regular services programs for the longer term. SAMHSA received mission assignments from FEMA for the first time, including assignments to support the cruise ships in the New Orleans and Pascagoula, Mississippi, harbors, and to support mental health and substance abuse workers in Louisiana and Alabama. An appeal for Mississippi's request for a substance abuse and mental health mission assignment denied by FEMA is pending. SERC planning staff first estimated the scope of the disaster and then mapped that information to target assistance to grantees.

Ms. Herron explained that SAMHSA expanded its website to include information on hurricane response, arranged for creation of public service announcements, and updated substance abuse-specific information, all of which appear on the website. Ms. Bruun stated that SAMHSA mobilized the National Suicide Prevention Hotline as a central point of access for information and assistance. Ms. Bruun and Ms. Herron described SAMHSA's process for supporting deployed personnel, including a contractor to manage deployment, go-packs with emergency information and supplies, orange T-shirts for identification, and frequent personal contact.

SAMHSA continues to provide services, but with a longer-term focus. Referrals to services have increased, and long wait times are being addressed. Providers observe significant alcohol, opiate, and prescription drug misuse; pain management issues; domestic violence, child abuse, and assault; co-occurring disorders; and, on cruise ships, feelings of isolation, child care issues, and frustration and anger.

Discussion. Council members congratulated SAMHSA on its work, and presenters responded to members' questions. Ms. Herron stated that the 9/11 response benefited from far less infrastructure loss than hurricane-affected areas, many of which still lack electricity. A lessons-learned document is forthcoming. CSAT's Arlene Stanton described methadone treatment challenges during 9/11, but noted that several stakeholders have since helped SAMHSA and CSAT develop a centralized online database to access and verify methadone dosing information, and a pilot project will be developed following creation of the infrastructure. Dr. Madrid stated that in the aftermath of the hurricanes, his organization provided methadone to evacuees and former inmates, and the inmates disappeared by the next day. Ms. Bruun stated that forensic sheltering and care provision is an area that warrants attention. Dr. Clark raised the related issues of maintaining contact with persons under parole and probation supervision, monitoring sexual predators, and dealing with opiate users whose supplies suddenly are disrupted.

ATR - Council Support. The Council unanimously agreed to send a letter to the HHS Secretary expressing support for the goals of ATR and the manner and method by which SAMHSA/CSAT has assisted states in transforming their systems to integrate recovery support, including support by faith-based organizations, into the substance abuse system of care.

Public Comment. There were no comments from the public.

Rapid HIV Testing Initiative. Kirk E. James, M.D., HIV/AIDS Coordinator and CSAT Participant Protection Officer, Systems Improvement Branch, CSAT, presented an overview of this SAMHSA-wide project. Dr. James reported that 1993-2003 data show increasing numbers of persons with HIV/AIDS and proportionally increasing numbers of African Americans and Hispanics. Transmission data show 63 percent of cases in males from male-to-male sexual contact and 17 percent from heterosexual contact, and 14 percent from injection drug use (IDU) (compared to 19 percent IDU for females).

Dr. James explained that the \$4.8 million, two-year initiative provides rapid HIV testing kits and training and technical assistance to facilitate the project. The project aims to provide rapid HIV testing capability to SAMHSA's grantee sites, outreach to underserved minority and other high-risk populations in nontraditional settings, and retest individuals who previously tested negative. Pre- and post-test counseling is mandated in the program, which targets persons with substance abuse, mental health, and co-occurring disorders; injection drug users; commercial sex workers; and re-entry populations. CDC is among SAMHSA's partners in the project. Four million dollars was allocated to purchase test kits, which produce results within a 40-minute period.

The media have reported false positives in oral-fluid testing, but the FDA has found the numbers of false positives expectable under the label. FDA is working with SAMHSA, CDC, and the manufacturer to ensure that false positives do not exceed acceptable boundaries.

Dr. James described the program orientation process, site selection, state readiness requirements, training and technical assistance for administering the tests, and data collection and evaluation. The initiative will look at process measures, intermediate and long-term outcome measures, and the data collection component. Site, individual, and product data have been collected in anticipation of developing a repository of information to incorporate into SAMHSA's Services Accountability Improvement System.

Preliminary data show that most clients were tested in New York and Houston (13,000 clients). By December 2005, 352,000 kits had been distributed across the country. Sites included field visits (39 percent), public health centers (28 percent), criminal justice settings (11.2 percent), and drug treatment sites (6.6 percent). Mainly males were tested, and mainly African Americans, Hispanics, and others (compared to 31.5 percent for white non-Hispanics). Most persons tested were ages 20-39. Participants self-reported on their reasons for testing. Results showed that 99 percent of participants remained to hear the results of their tests, and that 1.5 percent were preliminarily positive and required follow-up testing. In closing, Dr. James highlighted the mention of rapid HIV testing in the State of the Union message.

Discussion. Dr. James stated that the initiative does not fund confirmation tests, but that states in the program have established referral links. He noted that innovative, nontraditional means of reaching individuals for tested are encouraged.

Council Roundtable. Ms. Jackson inquired whether e-therapy will continue as an interest of the Council, and Dr. Clark stated his intention to revisit the issue. Dr. McCorry suggested a presentation on sustainability of funding systems for programs, and Dr. Clark noted that the issue relates also to workforce training and reimbursement for new services in a delivery system's portfolio. Dr. Madrid added that prospective local service providers have voiced concerns about reimbursement. Mr. DeCerchio supported a presentation focused on operational matters, for example, agreement on outcome measures across agencies. Ms. Bertrand identified the need for workforce leadership development. Ms. Jackson pointed to opportunities for large funders, such as the Ryan White program, to invest in substance abuse treatment. She also noted that differences in services across agencies produce variability in national outcomes. Dr. McCorry asserted that the criminal justice, public welfare, and public health systems should invest in treatment as part of their mission. Dr. Madrid suggested adding the issue of infectious diseases to the agenda, and Dr. Clark asked Council members to be aware of community activities and the need for educating clinical programs about the importance of immunization.

Adjournment. Dr. Clark noted that Council will have a face-to-face meeting on June 23, 2006, teleconference meeting on August 24, and a face-to-face meeting on September 21-22. The meeting adjourned at 12:48 p.m.

09/18/06
Date

/s/
H. Westley Clark, M.D., J.D., M.P.H.
Chair
CSAT National Advisory Council
Director
SAMHSA's Center for Substance Abuse Treatment